STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445276	A. BUILDING _____ B. WING _____	03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND VILLAGE CARE AND REHABILITATION CENTER	136 DAVIS LANE LAFOLLETTE, TN 37766

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #'s 26942, 27119, 27283, 27617, were completed at Cumberland Village Care and Rehabilitation Center on March 28-30, 2011. No deficiencies were cited for the complaint investigations.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Cumberland Village Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to check placement of a feeding tube prior to administration of medications, and failed to maintain clean technique while giving medications through the feeding tube for one resident (#13) of thirty-two residents reviewed. The finding included: Resident #13 was readmitted to the facility on January 22, 2011, with diagnoses including Late Effects of Cerebral Vascular Accident, Hypertension, Diabetes, Alzheimer's Disease, and Dysphasia. Continued medical record review of the Minimum Data Set dated January 22, 2011, revealed the resident received nutrition through a	F 322	<u>F 322 - (D)</u> 1. Resident #13 was re-assessed by the Director of Nursing Services on 3/29/11 with no adverse findings. The tube feeding for resident #13 was changed by the Director of Nursing Services on 3/29/11. LPN #1 was provided re-education on 3/29/11 by the Regional Director of Clinical Operations regarding infection control technique related to percutaneous endoscopic gastrostomy (PEG) tubes. LPN #1 was re-educated by the Director of Nursing Services on 4/1/11 regarding maintaining clean technique while giving medications through the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 04/12/2011

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F 322	Continued From page 1 percutaneous endoscopic gastrostomy (PEG) tube, and was total dependent for all activities of daily living. Observation on March 29, 2011, at 7:50 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #1 administering medications to the resident. Continued observation revealed LPN#1 disconnected the tubing from the PEG and without checking placement of the feeding tube administered medication through the feeding tube. Review of the facility policy Enteral Nutrition revealed...Implementation...2.b. for continuously tube fed clients, test placement every 4 to 12 hours and before medication administration. Interview with LPN #1 on March 29, 2011, at 8:15 a.m., in the hallway, confirmed the placement of the feeding tube was not checked prior to administration of medications. Further observation at the time of medication administration revealed LPN #1 disconnected the tubing from the PEG, draped the tubing over the side rail of the bed, and flushed the PEG Continued observation revealed the tubing had fallen to the floor. Continued observation revealed the LPN#1 layed the tubing on the bed mattress, went to the bathroom, wet a paper towel, returned to the bedside, wiped the tubing with the wet paper towel and reconnected the tubing to the PEG. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on March 29, 2011, at 2:25 p.m., in the DON's office, confirmed clean technique was not followed for	F 322	feeding tube and checking placement of a feeding tube prior to administration of medications. 2. Current residents with (PEG) tubes were re-assessed by a licensed nurse on 3/30/11 with no adverse findings. 3. The Staff Development Coordinator will complete re-education with licensed nurses on maintaining clean technique while giving medications through the feeding tube and checking placement of a feeding tube prior to administration of medications. This education will be completed by 4/15/11. 4. The Director of Nursing Services, Assistant Directors of Nursing Services, Staff Development Coordinator, or Pharmacy Consultants will observe medication administration opportunities with gastrostomy tubes (3) times weekly for (4) weeks and (1) time monthly for (2) months to monitor for checking placement of the feeding tube and maintaining clean technique. The Director of Nursing Services or Assistant Director of Nursing Services will present findings from gastrostomy tube medication administration	

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F 322	Continued From page 1 percutaneous endoscopic gastrostomy (PEG) tube, and was total dependent for all activities of daily living. Observation on March 29, 2011, at 7:50 a.m., in the resident's room, revealed Licensed Practical Nurse (LPN) #1 administering medications to the resident. Continued observation revealed LPN#1 disconnected the tubing from the PEG and without checking placement of the feeding tube administered medication through the feeding tube. Review of the facility policy Enteral Nutrition revealed...Implementation...2.b. for continuously tube fed clients, test placement every 4 to 12 hours and before medication administration. Interview with LPN #1 on March 29, 2011, at 8:15 a.m., in the hallway, confirmed the placement of the feeding tube was not checked prior to administration of medications. Further observation at the time of medication administration revealed LPN #1 disconnected the tubing from the PEG, draped the tubing over the side rail of the bed, and flushed the PEG Continued observation revealed the tubing had fallen to the floor. Continued observation revealed the LPN#1 layed the tubing on the bed mattress, went to the bathroom, wet a paper towel, returned to the bedside, wiped the tubing with the wet paper towel and reconnected the tubing to the PEG. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on March 29, 2011, at 2:25 p.m., in the DON's office, confirmed clean technique was not followed for	F 322	monitoring to the Process Improvement Committee monthly for three months. The Process Improvement Committee consists of the Administrator, Director of Nursing Services, Medical Director, Assistant Administrator, Assistant Directors of Nursing Services, Clinical Case Manager, MDS Coordinator, Health Information Manager, Business Office Manager, Housekeeping and Laundry Supervisor, Infection Control Nurse, Social Service Director, Activities Director, and Pharmacy Consultant. Subsequent plans of correction will be implemented as necessary based on the observation results.	4/18/11

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F 322	Continued From page 2 the tube feeding disconnect, and verified the tubing needed to be changed after touching the floor.	F 322		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the proper holding temperature of three hot food items on the tray preparation steam table. The findings included: Observation with Cook #1 on March 28, 2011, at 12:00 p.m., in the kitchen at the tray preparation steam table, revealed three hot food items with a holding temperature below the required minimum 141 degrees F (Fahrenheit). 1. Chicken breasts at 128 degrees F. 2. Creamed corn at 130 degrees F. 3. Chopped beef for a mechanical diet at 128 degrees F. Interview with Cook #1, at the time of the	F 371	F 371 - (F) 1. The hot food items were removed from the tray preparation steam table by the Nutritional Service Director on 3/28/11 and were re-heated to above 165 degrees prior to serving and maintained above 141 degrees minimum holding temperature. Re-education was provided to Cook #1 on 3/30/11 by the Nutritional Service Director regarding acceptable food temperatures. 2. Food temperatures were checked by the Nutritional Services Director on 3/29/11 prior to the breakfast and lunch meal service with no adverse findings. No residents were affected. 3. The Nutrition Services Staff were re-educated on 3/30/11 by the Nutritional Service Director and Regional Dietician regarding hot-held minimum internal temperatures for potentially hazardous foods and the policy and procedure on checking and recording food temperatures.	

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F 322	Continued From page 2 the tube feeding disconnect, and verified the tubing needed to be changed after touching the floor.	F 322	4. The food temperatures will be checked prior to (2) meals daily for (2) weeks by the Nutritional Service Director or Dietary Staff, then (3) times weekly for (4) weeks. The food temperature findings will be reported to the Process Improvement Committee monthly for (3) months. The Process Improvement Committee consists of the Administrator, Director of Nursing Services, Medical Director, Assistant Administrator, Assistant Directors of Nursing Services, Clinical Case Manager, MDS Coordinator, Health Information Manager, Business Office Manager, Housekeeping and Laundry Supervisor, Infection Control Nurse, Social Service Director, Activities Director, and Pharmacy Consultant. Subsequent plans of correction will be implemented as necessary based on the observation results.	4/18/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the proper holding temperature of three hot food items on the tray preparation steam table. The findings included: Observation with Cook #1 on March 28, 2011, at 12:00 p.m., in the kitchen at the tray preparation steam table, revealed three hot food items with a holding temperature below the required minimum 141 degrees F (Fahrenheit). 1. Chicken breasts at 128 degrees F. 2. Creamed corn at 130 degrees F. 3. Chopped beef for a mechanical diet at 128 degrees F. Interview with Cook #1, at the time of the	F 371		

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F 371	Continued From page 3 observation, confirmed the food temperatures were below the required 141 degrees F.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	**F 441 - (D)** **1.** Resident #23's nose bleed was managed and the blood spill on the floor was cleaned using a blood spill kit by the CNA on 3/28/11. Resident #13 was assessed by the Director of Nursing Services on 3/29/11 with no adverse findings. Resident #13's oral suction catheter (tool) was changed by central supply clerk on 3/28/11. The feeding tubing for Resident #13 was changed by the Director of Nursing Services on 3/29/11. LPN #1 was provided re-education on 3/29/11 by the Regional Director of Clinical Operations regarding infection control technique related to percutaneous endoscopic gastrostomy (PEG) tubes. LPN #1 was re-educated by the Director of Nursing Services on 4/1/11 regarding infection control practices, procedure for cleaning blood spills, and maintaining clean technique for medication administration with gastrostomy tubes. Central supply clerk was re-educated on 3/28/11 by the Director of Nursing Service on infection control regarding preparation and storage of oral suction catheters.	

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F 441	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to follow the policy for cleaning a blood spill, for one resident (#23), and failed to maintain sanitary conditions for a suction catheter and maintain clean technique for a tube feeding for one resident (#13) of thirty-two residents reviewed. The findings included: Resident # 23 was admitted to the facility on November 2, 2010, with diagnoses including Dementia and Mental Retardation. Observation, during the initial tour, in the secure unit on March 28, 2011, at 9:15 a.m., revealed resident #23 sitting on the side of the bed and a Certified Nursing Assistant (CNA) attempting to stop a nosebleed with gloved hands and a wet wash cloth. Continued observation revealed blood on the floor next to the bed, across the floor to the doorway , and on the door frame entering the resident's room. Observation revealed Licensed Practical Nurse (LPN)#1 entered the room, retrieved paper-towels and with ungloved hands attempted to wipe blood from the floor. Continued observation revealed LPN #1 tossed the soiled paper towels in the bathroom trash can and without washing hands, exited the resident's room. Continued observation revealed LPN #1 instructed a CNA to retrieve bleach from housekeeping, to clean the blood from the floor.	F 441	4. The Director of Nursing Services, Assistant Directors of Nursing Services, or Staff Development Coordinator will interview (3) random employees per week for (4) weeks, then (1) time monthly for (2) months to monitor staff knowledge of the procedure for cleaning blood spills. The Director of Nursing Services, Assistant Directors of Nursing Services, or Staff Development Coordinator will observe suction catheters for appropriate dates and storage procedures, and gastrostomy tube medication administration opportunities to monitor for correct infection control procedures (3) times weekly for (4) weeks and (1) time monthly for (2) months. Director of Nursing Services or Assistant Director of Nursing Services will present findings from infection control procedure monitoring to the Process Improvement Committee monthly for three months. The Process Improvement Committee consists of the Administrator, Director of Nursing Services, Medical Director, Assistant Administrator, Assistant Directors of Nursing Services, Clinical Case Manager, MDS Coordinator, Health Information Manager, Business Office Manager, Housekeeping and Laundry Supervisor, Infection Control Nurse.	

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F 441	Continued From page 5 Observation in the resident's room at 9:45 a.m., revealed a housekeeper delivered a bottle containing "bleach water" to LPN #1. Continued observation revealed LPN #1 handed the bottle to the CNA. Observation at 9:51 a.m., revealed the CNA exited the resident's room and retrieved a blood spill kit and utilized the kit to clean the floor and the door frame of the resident's room. Review of the facility's policy regarding blood spill clean-up revealed, "...gloves must be worn during cleaning and decontaminating procedures ...use kit located in medication room, emergency cart, nursing station, or pre-identified area." Interview with LPN #1 on March 28, 2011, at 9:52 a.m., in the resident's room, confirmed LPN #1 had not followed the facility's policy for cleaning a blood spill. Resident #13 was readmitted to the facility on January 22, 2011, with diagnoses including Late Effects of Cerebral Vascular Accident, Hypertension, Diabetes, Alzheimer's Disease, and Dysphasia. Continued medical record review of the Minimum Data Set dated January 22, 2011, revealed the resident received nutrition through a percutaneous endoscopic gastrostomy (PEG) tube, and was dependent for all activities for daily living. Observation during the initial tour with Licensed Practical Nurse #2 (LPN) on March 28, 2011, at 9:15 a.m., in resident #13's room, revealed the resident had a suction machine with clear liquid in the container, sitting on the bedside night stand. The LPN #2 opened the night stand drawer which revealed an oral suction catheter (tool) stored in a	F 441	Social Service Director, Activities Director, and Pharmacy Consultant. Subsequent plans of correction will be implemented as necessary based on the observation results.	4/18/11

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F 441	Continued From page 6 large clear plastic bag. Continued observation with the LPN revealed the suction catheter was dated March 3, 2011. Interview with the LPN #2 at the time of observation confirmed the suction catheter was dated March 3, 2011 (25 days) and stated "it should have been changed." Observation on March 29, 2011, at 7:50 a.m., in resident #13's room, revealed LPN #1 administering medications to the resident. Continued observation revealed LPN #1 disconnected the tubing from the PEG, draped the tubing over the side rail of the bed, and flushed the PEG. Continued observation revealed the tubing had fallen to the floor. Further observation revealed the LPN #1 layed the tubing on the bed mattress, went to the bathroom, wet a paper towel, returned to the bedside, wiped the tubing with the wet paper towel and reconnected the tubing to the PEG. Interview with the Director of Nursing (DON) and Assistant Director of Nursing on March 29, 2011, at 2:25 p.m., in the DON's office, confirmed clean technique was not followed for the tube feeding disconnect and verified the tubing needed to be changed after touching the floor.	F 441		